

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 09/23/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE LAKES HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the PSR completed on 8/5/11 to the Investigation of Complaint IN00091241 completed on 6/8/11.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/5/11.</p> <p>Complaint IN00091241: Corrected</p> <p>Survey dates: September 22 and 23, 2011</p> <p>Facility number: 012305 Provider number: 155779 AIM number: 200987990</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Michelle Hosteter, R.N. Heather Lay, R.N.</p> <p>Census bed type: SNF--57 SNF/NF--9 Residential--56 Total--122</p> <p>Census payor type: Medicare--23 Medicaid--1 Other--98 Total--122</p> <p>Residential Sample: 4</p> <p>Prairie Lakes Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B, and 410 IAC 16.2 in regard to the PSR to the</p>	{R 000}			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

OPF113

If continuation sheet 1 of 2

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{R 000}	Continued From page 1  PSR to the Investigation of Complaint IN00091241.  Quality review 9/26/11 by Suzanne Williams, RN	{R 000}			